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THE TREATMENT OF FISTULÆ IN ANO BY LANGE'S METHOD OF IMMEDIATE SUTURE OF THE TRACT.[1]

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THE reason for presenting this paper is an experience that justifies me in expressing an opinion of Lange's method of treating *fistulæ in ano* that is contrary to the unfavorable opinion of it held by the general surgeon, and, in fact, by some rectal specialists. I take it that the condemnation of this operation is due to a misconception of its scope or range of applicability, rather than to a failure to accomplish the desired results in suitable cases. Fistulous tracts running high into the bowel should not be treated by this plan, but in the majority of instances the sinuses are confined to the lower inch or so of the bowel. In such cases the technique to be described will often materially aid the healing process.

An inflexible rule to follow in all cases of *fistulæ in ano* cannot be given, as each case requires individual study and treatment.

Briefly stated, the method of treating the disease in question, as suggested by Dr. Frederick Lange, of New York City, consists in the excision of the entire fistulous tract, and the apposition of the

[1] Read before the Medical Society of the State of Pennsylvania, May, 1895.

wound by buried sutures of catgut, in order to secure healing by first intention. Strict antiseptic precautions are of course observed. In my own practice, for the past two years, I have pursued this treatment, with a few modifications, in nearly all the cases coming under observation that required operative interference. In no instance was there occasion to regret its employment. In those cases in which primary union was not secured the immediate suturing of the fistulous tract prevented hemorrhage and lessened pain, the pain being occasioned sometimes by the packing of the sinus when sutures are not employed. Frequently a portion of the wound healed by first intention, and shortened that much the period of convalescence.

The special points in the operative technique that I follow are as follows: The sphincter muscles are thoroughly stretched. Instead of attempting to excise the entire fistulous tract or tracts, the wall of the incised fistula is thoroughly curetted, and the edges of the sinus are removed if at all indolent. Bleeding, if profuse, is temporarily controlled by torsion of the vessel, or by the application of hot-water compresses. Silkworm-gut sutures are inserted in a similar manner to that employed in repairing a lacerated perineum, the sutures being passed at intervals of half an inch and about a quarter of an inch from the edge of the wound. It is a buried suture, that is to say, no portion is exposed within the sinus. After all the sutures are inserted they are tied with a single surgeon's knot.[1]

[1] I am indebted to Dr. B. F. Baer, of this city, for the suggestion to use silkworm-gut in these cases, and likewise for the information that a single surgeon's knot prevents any danger of this material slipping.

The ends of the gut should not be cut short, as they are liable to stick into the flesh. The tension exerted by the suture must not be excessive, only sufficient to bring the raw surfaces into accurate apposition. When more force than this is employed the wound is puckered, and healing is either prevented or seriously retarded. Superficial sutures are used wherever the skin or mucous membrane is not closely united, especial attention being paid to this, in order to prevent the entrance of fecal or foreign matter, which, should it occur, would prove disastrous to primary union. When the operation is completed a suppository of ten grains of iodoform, or five grains of aristol, is inserted into the bowel, and some of the dry powder is sprinkled over the external parts. A liberal supply of gauze and cotton and a T-bandage complete the dressing. No opium is given, if it is possible to avoid its use. The bowels are moved on the third day by the administration of small doses of calomel and sodium bicarbonate, followed by a saline. Immediately preceding the fecal movement an enema of six or eight ounces of olive-oil is given. This lubricates the parts and softens the stool. Patients are kept in the recumbent position from ten days to two weeks, the length of time being proportionate to the extent and depth of the lesion. Tuberculous subjects improve most rapidly when not confined to bed longer than absolute prudence demands.

During the healing process two points require the surgeon's attention, *the burrowing or formation of fresh sinuses* and *the onset of pain.*

The development of burrowing, or the formation of fresh sinuses, is generally indicated by the sud-

den appearance of an increased amount of purulent discharge, or by an induration of the tissues about the site of the former fistula. Upon discovering the seat of trouble the requisite number of sutures should be removed, and any adhesions that interfere with the wound healing from the bottom should be broken down with a probe so as to allow free drainage, and the tracts should be kept perfectly clean by frequent syringing with hydrogen dioxid, or some other antiseptic and pus-destroying solution. If a new sinus has formed, it should be opened at once.

Regarding the appearance of pain, Allingham[1] states: "Always encourage your patient to tell you directly he has any pain in or near the healing fistula; never make light of his complaints; often he will be the first to discover, by the existence of some unpleasant sensation, the commencement of a small abscess or sinus, and will be able also to indicate its situation."

Unless otherwise indicated, the sutures are removed within ten days or two weeks; frequently a few are taken out within a week. It is best, however, to err on the side of leaving them in too long.

In conclusion, I would state that, having given this operation a fair trial, I am inclined to consider it of decided advantage in the treatment of many cases of *fistula in ano*. Even if primary union is not obtained, the patient will be in the same position as if no attempt had been made to secure it; whereas, if healing ensues, the gain is a very considerable one.

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